STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355111	A. BUILDING _____ B. WING _____	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES SUNRISE CARE CENTER	705 SE 4TH ST CROSBY, ND 58730

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on August 7, 2016 and completed on August 10, 2016, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		9/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/23/2016

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F 156	Continued From page 1	F 156		

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with

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F 156	Continued From page 2 the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A notices/files and staff interview, the facility failed to provide adequate written notices to 3 of 3 sampled residents (Resident #5, #10, and #11) or their representatives before Medicare Part A coverage and/or services ended. Failure of the facility to provide an opportunity to request a demand bill (Resident #11) and/or notices that contained the correct contact information for the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), limits the residents ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare Part A notices/files for Resident #5, #10, and #11 occurred on 08/09/16. The facility's Notice of Medicare Non-Coverage	F 156	1) Resident's # 5, # 10 and # 11 will have a formal letter sent to the responsible party to inform them of incorrect information on their previous notice. Resident # 11 responsible party has been contacted and refuses need for demand bill. 2) Resident's admitted to Medicare services have the potential to be affected by this deficient practice. 3) The Mandatory Denial Notice has been updated with the correct QIO KEPRO information. 4) An audit will be completed monthly x 12 months by the MDS nurse to verify that the correct QIO KEPRO information is on each mandatory denial notice and that the demand bill section is appropriately completed by the responsible party. The audit will be	

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F 156	Continued From page 3 form (CMS 10123-NOMNC) contained the incorrect QIO name and toll free number. The following Notices of Medicare Non-Coverage forms failed to have the correct KEPRO name and toll free telephone number. * Resident #5's - signed 04/27/16. * Resident #10's - signed 02/11/16. * Resident #11's - signed 02/16/16. Review of Resident #11's Mandatory Denial Notice, signed 02/16/16, identified the facility failed to verify if the resident's representative requested the bill be submitted for a Medicare decision by checking yes or no on the form. During an interview on 08/09/16 at 4:30 p.m., a nursing staff member (#7) reported she was unaware of the new QIO KEPRO, which went into effect 08/01/14.	F 156	reviewed monthly at the Quality Assurance meetings.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as	F 157		9/23/16

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F 157	Continued From page 4 specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to promptly notify the resident's physician of concerns for 2 of 9 sampled residents (Resident #1 and #6). Failure to promptly notify the physician of low and high blood glucose levels (Resident #1) and following a fall (Resident #6) may have resulted in delayed treatment for Resident #1 and #6. Findings include: Review of the facility policy titled "Blood Sugar Monitoring" occurred on 08/10/16. This undated policy stated, ". . . If blood glucose level is above or below the normal range, document the time the physician was notified. . . ." Review of the facility policy titled "Hypoglycemic Incidents" occurred on 08/10/16. This undated policy stated, ". . . 2. For blood glucose levels of	F 157	1) Residents # 1 was seen on 10/20/2015 and notification of low blood glucose readings on 9/27/2015, 9/29/2015, 10/04/2015, 10/06/2015 and 10/08/2015 was reviewed resulting in changes to insulin medication. Resident was seen on 6/21/2016 for a routine exam, while this was not timely notification of high blood gluose readings from 9/26/2015, 5/30/2016, 6/1/2016, 6/2/2016, 6/5/2016, 6/6/2016, 6/7/2016, 6/13/2016 and 6/16/2016, the physician has been notified of events and appropriate changes to insulin medications has been made. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) The policy has been updated for hypoglycemic incidents. A policy has	

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F 157	Continued From page 5 70 or below, or physicians guidelines, . . . e. Notify physician. . . . 3. For blood glucose levels 45 or below . . . d. Notify physician immediately, if physician is not available, contact physician on call for attending physician or the medical director; if not available contact the emergency room for direction. . . ." The facility policy titled "Falls or Injured Resident" occurred on 08/10/16. This undated policy stated, ". . . Procedure . . . 10. Notify the physician and follow any orders as directed. Documents [sic] the physician's response in the electronic medical record. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, hypertension, and diabetes. The physician's order, dated 04/14/15, stated, ". . . [change] BS [blood sugar] parameters. Notify MD [medical doctor] if < [less than] 50 or > [greater than] 350. The physician's order, dated 10/20/15, stated ". . . call on call provider if Accu [blood sugar] < 80 , > 400 . . ." The resident's current care plan stated, ". . . Focus . . . has Diabetes Mellitus R/T [related to] need for insulin M/B [manifested by] elevated blood sugars . . . Interventions/Tasks . . . call provider with any blood sugar <80 or >400 . . . Focus . . . has hypertension (HTN) r/t fluctuation in blood sugar . . . Interventions/Tasks . . . notify MD if BP [sic] <50, or >350 . . ." Review of the residents progress notes showed the following: * 09/26/15 at 2:56 a.m.: "Found resident incoherent, rolling back and forth in bed, cold and	F 157	been written for hyperglycemic incidents. Regarding notification of hypo-hyper glycemic episodes the nursing staff will now communicate a hypoglycemic episode using an inter-facility custom form. All hyperglycemic episodes will require a telephone call to on call provider. All nursing staff will be educated on new policies. 4) An audit will be completed weekly x 4 weeks, bi-weekly x 2 months and then monthly x 10 months on all diabetic residents receiving insulin. Audit will be completed by Infection Control Nurse to confirm that any hypo or hyper glycemic episodes are reported to providers per policy. The audit will be reviewed at the monthly Quality Assurance Meetings. 1) The provider has been notified of fall without injury on 2/24/2016 for resident # 6. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) The nursing staff has been educated regarding the importance of notification of providers following an incident at nurses meetings held in August and September. 4) An audit will be completed weekly x 4 weeks, bi-weekly x 2 months and then monthly x 10 months on all incidents in the facility. The audit will be completed by DON to confirm appropriate communication is completed and documented per policy. The audit will be reviewed at monthly Quality Assurance Meetings.	

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clammy, and yelling out. Blood sugar was 37. Attempted to give juice, but resident clamped mouth closed. Gave prn [as needed] GlucaGen 1 mg [milligram] injection to left deltoid, with good results. Within 10 minutes residents blood sugar went up to 75 and he was once again alert and appropriate. Will continue to monitor and assist as needed. Call light in reach."
* 09/26/15 at 11:06 p.m.: "Resident refused evening meal, writer took his bs before hs [hour of sleep] insulin and results were 106, so writer held 70/30 d/t [due to] hypoglycemic episode this am."
* 09/27/15 at 9:46 p.m.: "Resident continues not to eat dinner or snack. His bs was at 144, so writer held his 70/30 insulin . . ."
* 09/29/15 at 4:55 a.m.: "While writer was doing rounds at 0330 [3:30 a.m.], writer observed resident as being diaphoretic and not responding properly to verbal commands. Writer had taken residents blood sugar which was 36. Writer then gave resident juice with sugar, . . . and [an] hour later at approximately 0435 [4:35 a.m.] and his blood sugar came up to 89. Resident still noted to be diaphoretic and confused, writer administered 240 cc [cubic centimeters] of juice with sugar. Writer checked residents bs once again and the results were 148 and resident was no longer diaphoretic nor did he appear to be as confused . . ."
* 10/04/15 at 6:40 a.m.: ". . . Novolin [insulin] 70/30 suspension Inject 68 units subcutaneously in the morning, Call MD [medical doctor] if BS<50 or >350 . . . Resident's BS 73. Glass of OJ [orange juice] provided. Will recheck and administer after breakfast if BS is increased."
* 10/04/15 at 8:54 a.m.: "Resident's BS rechecked, currently 255. Novolin 70/30 insulin

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F 157	Continued From page 7 administered as ordered." * 10/04/15 at 3:59 p.m.: "wife [resident's wife name] stopped by my office, she just returned from outing with husband [name], she said he was just 'out of it, he was confused and hallucinating. Said he seen a buick car up on ceiling, was calling children by wrong names, looking at her with blank stare: she said he was refusing snacks and sleeping a lot. Was concerned if he had another TIA [mini stroke]. will notify CN [charge nurse] and monitor his behavior." *10/04/15 at 4:36 p.m.: " Blood sugar was 146 [taken at 4:29 p.m.] . . ." * 10/06/15 at 8:23 p.m.: "FSBS [fasting blood sugar] 60: scheduled insulin held at this time . . ." * 10/08/15 at 3:21 a.m.: ". . . Resident confused and disoriented. Skin clammy. FSBS [fasting blood sugar] 36 . . ." * 10/08/15 at 3:21 a.m.: "Glucagon Emergency Kit 1 MG" given. Review of Resident #1's medical record identified the facility failed to notify the physician for low blood sugars less than 50, fluctuating blood sugar incidents, and interventions implemented for fluctuating blood sugars (e.g. [for example] withholding administration of insulin and administration of glucogon). Review of the resident's medical record showed the following blood sugar results: * 05/30/16: 498 * 06/01/16: 424 * 06/02/16: 410 * 06/02/16: 418 * 06/05/16: 428 * 06/06/16: 421 * 06/07/16: 432	F 157		

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F 157	Continued From page 8 * 06/13/16: 448 * 06/16/16: 452 Review of Resident #1's medical record identified the facility failed to notify the physician for high blood sugars greater than 400. - Review of Resident #6's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 05/19/16, identified two falls occurred. Review of Resident #6's fall incident reports identified a fall occurred on 02/24/16 at 9:52 p.m. This incident report stated, ". . . Resident was sitting in her w/c [wheelchair] after supper sitting in the living room and I heard a noise and saw her w/c tipping to her left side. She did not hit her head and was lying on the rug. The w/c was under her legs. . . ." This incident report identified no physician notification. The facility failed to notify the physician of this fall. During an interview on 08/09/16 at 2:04 p.m., an administrative nurse (#1) stated she expected staff to notify the physician when a fall occurs and a change in the resident's condition.	F 157		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff	F 170	1) All residents have been notified at the	9/23/16

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F 170	Continued From page 9 interview, the facility failed to provide mail delivery on Saturday for 9 of 9 residents interviewed. Failure to provide mail delivery on Saturdays infringes on the rights of all residents in the facility. Findings include: The resident group interview occurred on 08/08/16 at 2:01 p.m. and included nine residents (Resident A, B, C, D, E, F, G, H, and I) identified by the facility as interviewable. When asked about the mail delivery on Saturdays, two residents (A and B) stated they do not receive mail on Saturdays and the other residents confirmed the statement. Resident (C) stated it depends on who is working on the Saturday if they get the mail delivered as it is locked up in the nurses' station. During an interview on 08/10/16 at 8:50 a.m., a business office staff (#12) stated the mail is delivered on Saturdays to the facility and then locked up in the medication room until Monday when either she or another staff member (#13) deliver the mail to the residents.	F 170	resident council meeting that mail will now be delivered on Saturdays by staff. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) Nursing and CNA staff were educate on deficiency and the resident's right to receive mail. A CNA is appointed each Saturday by staffing coordinator to deliver mail. 4) An audit will be completed monthly x 12 months by office staff verifying that resident received their mail on Saturdays. The audit will be reviewed at monthly Quality Assurance Meetings.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility	F 176	1) Resident # 8 has been evaluated for	9/23/16

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F 176	Continued From page 10 policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 9 sampled residents (Resident #8) observed with medications left in the resident's bathroom. Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self-Administration of Drugs" occurred on 08/10/16. This undated policy stated, ". . . 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. . . . 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. . . . 9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage . . ." Observation during the initial tour on the afternoon of 08/07/16 showed a tube of triamcinolone Acetonide cream 0.1% labeled with Resident #8's name in the bathroom shared with Resident #12. Review of Resident #8's medical record occurred on 08/10/16. Resident #8's medical record lacked a SAM assessment. Review of Resident #12's medical record occurred on 08/10/16. Resident #12's quarterly Minimum Data Set (MDS) identified impaired cognition.	F 176	self evaluation of medications. Resident currently states he would rather have nursing staff apply triamcinolone Acetonide cream 0.1%. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All residents will now have a self-administering evaluation completed upon admission and with each yearly MDS review. All nursing staff have been educated at meetings in August and September to discuss change in practice. 4) An audit will be done monthly x 12 months by the MDS nurse to verify that residents who are self-administering medications have the assessment completed yearly and are following facility policy for storage of medications in room. The audit will be reviewed monthly at the Quality Assurance Meetings.	

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F 176	Continued From page 11 During an interview on 08/10/16 at 8:30 a.m., an administrative nurse (#1) confirmed Resident #8 and #12 had not been assessed to self-administer medications.	F 176		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility staff failed to provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity/self-esteem with chairs observed in public areas on 4 of 4 days of survey (August 07-10, 2016). Failure to remove cloth incontinence protectors from residents' chairs in the activity room, resident lounge/chapel, and hallway lounge area does not promote resident's dignity or enhance their quality of life. Findings include: Observation showed the following: * 08/07-10/16: Cloth incontinence protectors on twenty-five chairs in the resident lounge/chapel area. The chapel area had a strong pungent urine odor. * 08/08/16: Random observation in the 100/200 resident hallway lounge of a resident and their family member seated on two chairs with the	F 241	1) Cloth protectors will be removed from all sitting chair in the main living room, chapel and activity room. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) Cloth protectors will be removed from all sitting chairs in the main living room, chapel and activity room. Cloth protectors will continue to be used in reclining chairs, but will be removed after each resident leaves the chair. Cloth protectors will be placed underneath a resident if there is concern for incontinence while sitting in a chair. When a resident leaves a chair the cloth protectors will be removed and sent to laundry. All nursing staff have been educated on change of practice at meetings in August and September. All Environmental Services staff have been educated on	9/23/16

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F 241	Continued From page 12 cloth incontinence protectors. * 08/08/16 and 08/10/16: Cloth incontinence protectors on sixteen chairs in the resident activity room. During the group interview on 08/08/16 at 2:01 p.m., 2 of 9 residents that attended the meeting voiced concern about the cloth incontinence protectors located throughout the facility. Resident A stated "we have to feel the seat to see if they are wet before we sit down." Resident B stated "they change the pads at night time, otherwise we just check to see if they are wet before we sit on them." During the environmental tour on 08/10/16 at 7:45 a.m., an interview occurred with environmental services staff members (#10 and #11) regarding the cloth incontinent chair protectors used throughout the facility. Staff member (#10) reported the protectors on the chairs are changed daily and once a week the chairs in the day area and chapel are cleaned. When asked if they were shampooed, the staff member stated no just cleaned. The staff member (#10) stated, "We have people that are incontinent and they move around to other chairs." These chairs are available for use and publicly viewed for all residents and visitors.	F 241	change of practice at meeting in August. 4) An audit will be completed by the Environmental Services Director weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 10 months. The audit will be reviewed monthly at the Quality Assurance Meetings.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of	F 246		9/23/16

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F 246	Continued From page 13 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 9 sample residents (Resident #7) received reasonable accommodation of needs regarding dining room table positioning. Failure to offer and provide appropriate dining room table height limited the residents access to meal items and limited the quality of the dining experience. Findings include: Review of Resident #7's medical record occurred on 08/09/16. Diagnoses included cerebral palsy and osteoporosis. The annual Minimum Data Set (MDS), dated 07/08/16, identified one sided impairment in range of motion of both the upper and lower extremity and set up assistance with eating. The current care plan stated, ". . . Focus . . . has limited physical mobility r/t [related to] contracture & deformities of [left] leg & arm due to cerebral palsy & fx [fracture] [left] arm M/B [manifested by] inability to transfer independently . . . Interventions/Task . . . [left] ARM HAS NO FUNCION [sic], LEFT LEG AND KNEE HAVE LITTLE FUNCTION . . . [RIGHT] ARM DECREASED MOBILITY DUE TO hx [history] OF FX . . . Focus . . . nutritional needs . . . Interventions/Tasks . . . provide a raised-edge plate . . ." Resident #7's dietary meal card lacked	F 246	1) Resident # 7 was evaluated by Occupational Therapist on 8/17/2016 to evaluate resident's needs. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) A table with lower height adjustments has been ordered. After table arrives in facility Occupational Therapist will re-evaluate resident # 7 to determine if lower height provides better accommodation of needs. Futures residents that show a decline in function will have an Occupational Therapy Evaluation ordered by Provider. Education was provided at nursing and CNA meetings in August and September. Additional education will be provided as future assessments are completed. 4) An audit will be completed by Dietary Services Manager on a monthly basis x 12 months to observe any residents who show a decline of function in the dining room. The audit will be reviewed at monthly Quality Assurance Meetings.	

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F 246	Continued From page 14 information to include a raised-edge plate during meals. Observations during meals showed the following: *08/08/16 at 8:00 a.m. and on 08/09/16 during lunch: Resident #7 seated in her wheelchair at the dining room table. The top of the table was even with the resident's neck line. The resident plate was too far away and attempted to reach the food on the table several times. Food dropped from the residents fork and regular plate as she tried to bring the food to her mouth. Food was observed on Resident #7's lap and on the floor in front of Resident #7's wheelchair. *08/10/16 at 8:19 a.m.: Resident #7 seated in her wheelchair at the dining room table. The table top was observed at mouth level. The resident attempted to reach the food as food dropped from the resident's fork and plate. Banana and egg pieces were observed on the floor below the resident. A glass of milk was placed on the left side of the plate. The resident with great difficulty moved the glass of milk to the right side of plate three times resting between each attempt before taking a drink. During an interview on 08/10/16 at 10:09 a.m., a dietary manager (#6) confirmed the resident required a raised-edge plate during meals. During an interview on 08/10/16 at 10:10 a.m., an administrative nurse (#1) stated Resident #7 lacked an assessment of dining needs.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		9/23/16

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F 253	Continued From page 15 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 1 hand washing sink located in the residents' dining room. Failure to ensure the hand washing sink drained properly has the potential for water to spill onto the floor and interfere with staff's ability to wash their hands. Findings include: During meal times in the residents' dining room on 08/08/16 between 8:00 - 8:30 a.m., and 12:00 - 12:15 p.m. observations occurred of staff washing their hands at the sink. Observation showed staff had to wait for the water to drain before they could wash their hands, as the sink would be full to the top. At one point, it took 4 minutes for the sink (a bathroom size fixture) to drain completely. During an interview on the morning of 08/10/16, a maintenance staff (#11) reported no knowledge of the sink's slow drainage.	F 253	1) Sink in dining room was deemed repaired by maintenance staff on September 13, 2016. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) Maintenance staff will check the sink on a weekly basis during their rounds and maintain proper operation. Staff educated provided at department head meeting and nursing and CNA meetings to explain importance of reporting issues at time of finding. Communication will continue through our maintenance log book. 4) Weekly audit will be done x 12 months by Environmental Services Manager through TELS system. Documentation is kept in the TELS system and is able to be reviewed and/or printed by Environmental Services Manager. Audit will be reviewed monthly at Quality Assurance Meetings.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274		9/23/16

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F 274	Continued From page 16 resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of professional literature, and staff interview the facility failed to complete a significant change status assessments (SCSA) for 1 of 9 sampled Residents (Resident #4). Failure to complete a SCSA on a timely basis limited the facility staff's ability to accurately assess each resident's status, identify, and implement appropriate care plan approaches. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 3.0, occurred on 08/10/16. This manual, revised October 2015, page 2-23 states,". . . A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ."	F 274	1) A correction for the missed significant change on resident # 4 has been completed. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) MDS nurse has been educated on the requirements of significant change. 4) An audit will be completed monthly by MDS nurse on 5 random residents to assess for significant change. The audit will be reviewed monthly at Quality Assurance Meetings.	

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F 274	Continued From page 17 Review of Resident #4's medical record occurred on August 7-10, 2016. Resident #4 admission MDS, dated 02/22/16, identified she required total dependence of one person with locomotion off the unit; extensive assistance of one person with bed mobility and locomotion on the unit; walking in the corridor did not occur; and limited assistance of one person for transfer, walking in room, dressing, and toileting. A quarterly MDS, dated 05/12/16, identified Resident #4 required extensive assistance of one staff for transfers, walking in room, walking in corridor, dressing, and toilet use; limited assistance of one staff for bed mobility and locomotion off the unit; and supervision of one person assist for locomotion on the unit. During an interview on 08/10/16 at 10:27 a.m., a licensed nurse (#7) stated,"I thought a significant change was three or more areas of improvement or decline in ADLs." Resident #4 showed improvement in three areas and decline in four areas of functional status. The facility failed to complete a significant change in status MDS.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		9/23/16

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F 278	Continued From page 18 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument 3.0 (RAI) User's Manual (Version 1.13) the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 9 sampled residents (Resident #8) coded with delusions and behaviors. Failure to accurately assess Resident #8 regarding delusions and other behaviors and code the MDS correctly does not reflect the resident's current status and may affect the level of care provided. Findings include: The Long-Term Care Facility RAI User's Manual,	F 278	1) A corrected MDS has been completed for Resident # 8. 2) All resident admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) The MDS nurse has been educated on reviewing each section prior to signing off the MDS. 4) An audit will be completed by MDS nurse weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 10 months on 2 random residents to ensure the MDS assessments are being coded correctly by other departments. The audit will be reviewed monthly at Quality Assurance	

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F 278	Continued From page 19 revised October 2015, page E-2 an E-3 states, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . ." delusion." The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 3 pages E-4 stated, ". . . E0200: Behavioral Symptom -Presence and Frequency. A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) . . ." - Review of Resident #8's medical record occurred on August 09-10, 2016. The resident's quarterly MDS, dated 06/30/16, identified delusions, verbal and other behaviors which occurred one to three days during the seven-day look-back period. The medical record lacked documentation to support the coding of delusions and other	F 278	Meetings.	

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F 278	Continued From page 20 behavioral symptoms.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to review and revise the care plan for 4 of 9 sampled residents (Resident #1, #2, #3, and #6). Failure to revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity of care. Findings include:	F 280	1) The plan of care has been corrected for residents # 1, # 2, #3 and # 6. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) The MDS nurse has been educated on the importance of keeping care plans up to date. 4) An audit will be completed by the DON weekly x 4 weeks, bi-weekly x 4 weeks	9/23/16

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F 280	Continued From page 21 Review of the facility policy titled "Care Plans - Comprehensive" occurred on 08/10/16. This undated policy stated, ". . . 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; . . . e. Reflect treatment goals, timetables and objectives in measurable outcomes; . . . 8. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease, hypertension, and diabetes. Resident #1's current care plan stated, ". . . Focus . . . [name of resident] has hypertension (HTN) r/t [related to] fluctuation in blood sugar . . . Interventions/Tasks . . . Notify MD [medical doctor] if BP [sic] <50, or > 350 . . ." Resident #1's physician orders stated the following: * 04/14/15: Change blood sugar parameters. Notify MD if <50 or >350. * 10/20/15: Call on-call provider if accuchecks <80 or >400. The facility failed to update the care plan to reflect the new blood sugar parameters as ordered by the physician. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and history of falls. The quarterly Minimum Data Set (MDS), dated 05/19/16, identified Resident #6 required	F 280	and monthly x 10 months on 3 random residents to ensure care plan is accurate. The audit will be reviewed monthly at Quality Assurance Meetings.	

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F 280	Continued From page 22	F 280		

extensive assistance with toileting and transfers and always incontinent.

The current care plan stated, ". . . Focus . . . [name of resident] has constipation r/t cognitive deficits, dementia M/B [manifested by] inability to be aware of need to deficate [sic] . . . Interventions/Tasks . . . Encourage [name of resident] to sit on toilet to evacuate bowels if possible, she needs limited to extensive assist of one . . ."

Observations throughout the survey showed Resident #6 required extensive assistance of two or more people for transfers and required extensive assistance of two people for check and change while in bed every two to three hours and as needed.

The facility failed to update the care plan to reflect the resident's current toileting care needs and failed to address the resident's transfer needs.

During an interview on the morning of 08/10/16, an administrative nurse (#1) stated she expected the care plans to be updated to reflect the current needs of the residents.

- Review of Resident #3's medical record occurred on all days of survey. Diagnoses include pressure ulcer of left and right buttock, stage 1. A physician order dated 07/28/16, stated, "Plus 2 supplement 3 oz [ounce] with med pass three times a day related to PRESSURE ULCER OF LEFT BUTTOCK, STAGE 1; PRESSURE ULCER OF RIGHT BUTTOCK, STAGE 1 . . ."

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F 280	Continued From page 23 Review Resident #3's current care plan stated, "Focus . . . has potential impairment to skin integrity r/t fragile skin, rednes [sic] to groin area, reddnes [sic] to buttocks . . . " The care plan failed to address Resident #3's current pressure ulcers. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses include history of Methicillin Resistant Staphylococcus Aureus (MRSA) Infection. The current care plan stated, "Focus . . . health monitoring concerns R/T MRSA M/B clinical lab results . . . Interventions/Tasks . . . encourage all staff and visitors to do good hand washing after leaving room, follow MRSA infection control guidelines as stated in the MRSA policies . . . private room or with a positive MRSA resident . . . standard precautions as well as contact precautions with urine, stool, and other body fluids . . . " During an interview on 08/09/16 at 5:15 p.m., an administrative nurse (#1) stated, "Resident #2 does not have MRSA." The facility failed to update Resident #2's care plan with his/her current condition regarding the history of the MRSA infection.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		9/23/16

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F 281	Continued From page 24 COLOSTOMY CARE 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to meet professional standards for quality of care for 1 of 1 sampled Resident (Resident #5) with a colostomy. Failure to ensure a qualified nurse provided colostomy care may result in improper placement, irritation, and/or breakdown of the skin. Findings include: Review of the facility procedures guideline titled "Colostomy Care" occurred on 08/10/16. This guideline, dated 2006, stated," . . . Basic responsibility . . . Licensed Nurse . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included colostomy. The quarterly Minimum Data Set (MDS), dated 06/02/16, identified an ostomy (colostomy). A physician order, dated 03/13/15, stated, "change colostomy appliance and bag every day shift every Wed [Wednesday], Sat [Saturday] . . ." The current care plan stated, ". . . health monitoring concern R/T [related to] colostomy . . . Intervention/Tasks. . . change bag as ordered and monitor stoma and surrounding skin for any problems, CN [charge nurse] . . . monitor BM's [bowel movement's] daily, CNA [certified nursing assistant] . . ." Observation on 08/08/16 at 7:58 a.m. showed a CNA (#8) provided bedside colostomy cares to Resident #5. Colostomy cares completed by the CNA (#8) included: appliance removal, skin and	F 281	1) All nursing and CNA staff have been educated that colostomy cares involving changes of appliance must be completed by nurse. Resident #5 has been educated on the importance of having a licensed nurse complete the appliance change. 2) All residents admitted to the skilled nursing facility with a colostomy have the potential to be affected by this deficient practice. 3) All nursing and CNA staff have been educated that colostomy cares involving changes of appliance must be completed by nurse. 4) An audit will be completed by the infection control nurse bi-weekly x 12 months to verify that the nurse is completing colostomy cares involving appliance changes. The audit will be reviewed monthly at the Quality Assurance Meetings. 1) The incorrect order referenced for resident # 6 was corrected prior to survey. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) Nursing staff will now begin inputting all orders into EMAR system. A second nursing staff member will review order for accuracy. Education has been completed at August and September meetings to discuss importance of appropriate medication order entry. 4) An audit will be completed by the DON bi-weekly x 12 months on 10 random orders to verify accuracy. The audits will be reviewed monthly at the Quality	

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F 281	Continued From page 25 stoma care, colostomy appliance cut and fit to stoma, and appliance placed around stoma. A nurse (#9) came to Resident #5's bedside after the colostomy appliance removal, observed the CNA (#8) providing colostomy cares, and left before colostomy appliance placement. The nurse (#9) failed to provide the colostomy care. During an interview on the afternoon of 08/09/16, an administrative staff member (#1) confirmed a licensed nurse is expected to complete all colostomy care, and CNAs are not trained to provide colostomy care. MEDICATION ORDERS 2. Based on record review, and staff interview, the facility failed to follow professional standards of practice regarding transcribing medication orders to the electronic medication administration record (eMAR) for 1 of 9 sampled residents (Resident #6). Failure to transcribe the correct dosage of Tylenol as ordered by the physician into Resident #6's eMAR may result in the resident receiving more than the recommended maximum daily dose of Tylenol. Findings include: Review of Resident #6's physician order, dated 04/30/16, stated, ". . . Tylenol ES [Extra Strength] 1 tab po [by mouth] [every] 6 hours PRN [as needed] pain/temp. . . ." During an interview on the afternoon of 08/09/16, an administrative nurse (#1) clarified Tylenol ES means 500 mg [milligrams] tablets.	F 281	Assurance Meetings. 1) The allergy for resident # 1 has been reviewed with family and removed as there is no allergy. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All nursing staff and HIM director have been educated on allergies being input into chart. Further allergies will not be placed until provider has confirmed the allergy. 4) An audit will be completed by the HIM director monthly on all allergies entered into the charts to confirm provider has approved allergy. The audit will be reviewed monthly at Quality Assurance Meetings.	

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F 281	Continued From page 26 Review of Resident #6's pharmacy review, dated 05/23/16, stated, ". . . Findings: . . . Tylenol order is 650 mg BID [twice a day] plus 650 mg [every] 6 [hours] PRN. Dx listed for Tylenol is GAD [generalized anxiety disorder]. Max [maximum] dose for Tylenol single dose recommended is 500 mg. . . . Recommendations to Nursing Staff: Correct diagnosis for Tylenol. . . . Recommendations to Providers: Max dose recommended for Tylenol, [especially] for [resident] age, is 500 mg. . . . *Please note PRN APAP [Tylenol] order is for 500 mg [by mouth] [every] 6 hours PRN pain /fever. order was incorrectly entered in EMAR. [signed by administrative nurse name] . . . Tylenol DC [discontinue] 650 mg dose . . . strength: 500 mg [signed by physician name] PO BID 1 tab." During an interview on the afternoon of 08/09/16, an administrative nurse (#1) confirmed the wrong dose of Tylenol was transcribed into the eMAR. ALLERGY 3. Based on record review and staff interview, the facility failed to follow professional standards of practice for 1 of 9 sampled residents (Resident #1) with an allergy. Failure to acknowledge a resident's allergy when administering foods and/or medications may result in negative outcomes and adversely affect the resident's physical, mental, and psychosocial well-being. Findings include: Review of Resident #1's medical record occurred on all days of survey. A physician order and the electronic medication administration record	F 281		

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F 281	Continued From page 27 identified an allergy to orange juice. Review of the resident's progress notes identified the following: * 07/13/16 at 7:14 a.m.: ". . . blood sugar is reading 73; he's alert. Orange juice and 2pcs [pieces] of cookies given." * 08/09/16 at 7:24 a.m.: ". . . blood sugar [at] 0644hrs [6:44 a.m.] was 66 . . . He's alert, 2 cans of orange juice given and 2pcs of cookies. . . ." * 10/04/16 at 6:40 a.m.: "Resident's BS [blood sugar] 73. Glass of OJ [orange juice] provided. . . ." During an interview on the afternoon of 08/10/16, an administrative nurse (#1) confirmed the orange juice allergy in Resident #1's chart and stated staff should not have given orange juice.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to provide the care and services necessary to ensure the highest degree of safety possible for 1 of 1 sampled Resident (Resident	F 309	1) All staff have been educated on providing appropriate liquids for residents. Resident # 7 will be monitored to ensure the correct consistency of liquids is provided at all times.	9/23/16

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F 309	Continued From page 28 #7) observed receiving the wrong consistency of liquids. Failure to implement diet orders of nectar thickened liquids resulted in Resident #7 coughing while drinking and placed the resident at risk for choking and aspiration. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., New Jersey, (2016), pages 1151 to 1152, states,"Dysphagia . . . unable to swallow . . . or aspirate food or fluids into the lungs-causing pneumonia [lung infection]. . . . Consider dysphagia if the client . . . coughs, chokes, or gags while eating. . ." Review of Resident #7's medical record occurred on August 09-10, 2016. Diagnoses included cerebral palsy (muscle disorder). The annual Minimum Data Set (MDS), dated 07/08/16, identified the resident's required supervision and set up help with eating. The current care plan identified," . . . Focus . . . has verbal communication deficit r/t dysphagia . . . Focus . . . nutritional needs M/B [manifested by] [resident name] has Diabetes Mellitus, need for diverticular diet, thickened liquids due to CP [Cerebral Palsy] . . . monitor/document/report PRN [as needed] compliance with diet 'consistent carbohydrate diet, small portions with nectar thick liquids' . . ." The speech/language pathology evaluation, dated 10/22/10, stated, ". . . Treatment Dx [diagnosis] dysarthria/dysphagia [speech difficulty/swallow difficulty] . . . Nectar thick liq [liquid] . . . Res [resident] will be risk free [of] aspiration. . ." The dietary order summary, dated	F 309	2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All CNA and nursing staff have been educated on providing appropriate liquids for residents. 4) An audit will be completed by the Infection Control nurse on 5 random residents bi-weekly x 1 month and monthly x 11 months to ensure residents are receiving the appropriate consistency of liquids. Audit will be reviewed monthly at Quality Assurance Meetings.	

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F 309	Continued From page 29 04/26/13, stated,". . . Nectar consistency . . ." Observation on 08/09/16, at 5:16 p.m., showed a certified nurse assistant (CNA) (#2) offered Resident #7 unthickened water in her room. Resident #7 took a drink of the thin consistency water and coughed three times while swallowing the liquid. During an interview on 08/10/16 at 10:09 a.m., two administrative staff members (#1 and #6) confirmed they expected staff to provide Resident #7 with nectar thickened liquids.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interview, the facility failed to provide the necessary assistance with activities of daily living (ADLs) for 3 of 9 sampled residents (Resident #1, #3, and #8) who required assistance with all nail care. Failure to provide assistance with nail care can result in poor personal hygiene and grooming. Findings include: During an interview on the afternoon of 08/08/16, a family member (A) identified a continued lack of	F 312	1) Appropriate nail care has been provided to residents #1, # 3 and #8. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All CNA and Nursing staff have been educated on providing appropriate nail care for residents at meetings held in August and September. 4) An audit will be completed by Staff Coordinator bi-weekly x 12 months on 6 random residents to ensure nail care is being completed appropriately by CNA	9/23/16

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F 312	Continued From page 30 nail care for a resident even after facility staff were notified. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included restless leg syndrome, muscle weakness, Alzheimer's disease, and diabetes. The quarterly Minimum Data Set (MDS), dated 05/12/16, identified limited assistance of one person with personal hygiene. A physician order stated, ". . . Fingernail care by nurse as needed for nail maintenance . . . Fingernail care by nurse every day shift every 4 weeks on [Thursday] for nail maintenance. . . . Toenail care done by nurse (diabetic) as needed for nail maintenance . . . Toenail care done by nurse (diabetic) every day shift every 4 weeks on [Thursday] for nail maintenance. . . ." Resident #1's current care plan stated, "Focus: . . . has an ADL self-care performance deficit r/t [related to] dementia, neuromuscular weakness, M/B [manifested by] needing help with keeping clean and groomed . . . Interventions/Tasks . . . is diabetic, nail care will be done by CN [charge nurse] . . . Focus . . has potential impairment to skin integrity r/t fragile skin, psoriasis nasal labial folds, scalp irritations, [left] toenail missing . . . Interventions/Tasks . . . Keep fingernails short. . . ." Review of Resident #1's electronic treatment administration record (eTAR)identified fingernail and toenail care was provided every four weeks from February through August 2016. Review of the eTAR identified no additional as needed (PRN) nail care was provided.	F 312	and nursing staff. Audit will be reviewed monthly at Quality Assurance meetings.	

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Observation on 08/08/16 at 3:10 p.m. showed two certified nurse assistants (CNAs) (#16 and #17) assisted Resident #1 with his shower. Resident #1's right toe nail was observed long, uncut, and hanging over the nail bed. The CNAs failed to inform the charge nurse of Resident #1's need for nail care.

- Review of Resident #8's medical record occurred on August 09-10, 2016. Diagnoses included diabetes and osteoarthritis. A physician order stated, ". . . Fingernail care by nurse (diabetic/Coumadin [blood thinner medication]) as needed for nail maintenance . . . Fingernail care by nurse (diabetic/Coumadin) every evening shift every 4 weeks on Thu [Thursday] for nail maintenance. . . ."

Resident #8's current care plan stated, "Focus: . . . has an ADL self-care performance deficit r/t Disease Process . . . osteoarthritis . . . Interventions/Tasks . . . is diabetic, Nail care will be done by Charge Nurse . . ."

Review of Resident #8's eTAR identified nail care was provided every four weeks from February through August 2016. Review of the eTAR identified no additional as needed (PRN) nail care was provided.

Observation on 08/08/16 at 2:00 p.m. and 5:12 p.m. showed Resident #8's hands and fingernails visibly dirty with an orange/brown stain underneath the nails.

- Review of Resident #3 medical record occurred on all days of survey. Diagnoses included age-related physical debility and dementia.

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F 312	Continued From page 32 Resident #3's current care plan stated, "Focus: . . . has an ADL self-care performance deficit r/t [related to] Limited Mobility, Aging Process, needing more assistance with ADL's . . . Interventions: . . . provide nail care as needed . . . " Review of Resident #3's medical record identified staff provided nail care on 04/15/16, 04/28/16, and 07/28/16. The record lacked any nail care provided for the months of May and June. During an interview on the morning of 08/09/16, an administrative nurse (#1) reported the bath aides should be assessing the need for nail care. The facility failed to provide nail care as needed for the residents.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement interventions to prevent skin	F 314	1) The correct cover for pressure relief cushion for Resident # 3 was placed during survey.	9/23/16

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F 314	Continued From page 33 breakdown and the development of pressure ulcers for 1 of 3 sampled residents (Resident #3) with a current pressure ulcer. Failure to correctly implement interventions for pressure relief (i.e. pressure relief cushion) may result in further skin breakdown and delay healing. Findings include: Review of facility policy titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 08/10/16. This undated policy stated, ". . . Procedure: . . . 4. . . . Risk factors are those facts that increase a resident's susceptibility to develop or impact healing times of pressure ulcers. They include, but are not limited to: . . . Cognitive impairments, Exposure of skin to urinary and fecal incontinence, Malnutrition, under nutrition, and hydration deficits . . . 6. . . . any resident at risk will be placed on pressure redistribution surface as determined appropriate. . . . 11. The interdisciplinary teams should determine any modifications that are necessary to the resident's plan of care. . . ." Review of Resident #3's medical record occurred on all days of survey. Diagnoses include age-related physical debility, dementia, and pressure ulcers. Review of an admission Minimum Data Set (MDS), dated 04/15/16 identified cognitive impairment, incontinent of bowel and bladder, two Stage 1 pressure ulcers, and a pressure reducing device for chair and bed. A quarterly MDS, dated 07/07/16 identified cognitive impairment, incontinent of bladder, weight loss, and pressure reducing device for bed.	F 314	2) All resident admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All CNA and Nursing staff have been educated on the pressure relief cushion and the importance of providing the correct cover for the cushion. 4) An audit will be completed by the PT department weekly x 4 weeks then monthly x 11 months to ensure all cushion have the correct covers in place. The audit will be reviewed monthly at the Quality Assurance Meetings.	

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F 314	Continued From page 34 Review of Resident #3's current care plan identified, "Focus . . . has potential impairment to skin integrity r/t [related to] fragile skin, rednes [sic] to groin area, reddnes [sic] to buttocks . . . Interventions . . . assess skin daily for any potential high risk areas of concern . . . Avoid . . . excessive moisture . . . pressure relief mattress on bed . . . " The care plan failed to address Resident #3's current pressure ulcer and the current use of a pressure relief cushion. Review of Resident #3's "Wound/Skin Healing Record" identified an onset date of 04/12/16 for a Stage 1 pressure ulcer on the left buttock measuring 5 centimeters (cm) and a Stage 1 pressure ulcer on the right buttock measuring 5 cm. The Wound Record showed the last assessment occurred on 06/23/16 and stated, "3 cm pink/red area." A nursing progress note, dated 06/29/16, stated, ". . . There has been no change in skin condition and he has no open areas. . . . Will DC [discontinue] skin assessments at this time as staff is toileting and applying ointment several times a day." A "Wound/Skin Healing Record," dated 07/28/16, identified the onset of a Stage 1 pressure ulcer on Resident #3's left buttock measuring 6 by 4 cm and a Stage 1 pressure ulcer on the right buttock measuring 8 by 5 cm. Observations on 08/08/16 at 1:30 p.m. and 4:15 p.m. and 08/09/16 at 8:20 a.m. and 9:45 a.m., showed a pressure relief cushion with a cloth incontinent protector bunched up on top of the	F 314		

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F 314	Continued From page 35 cushion in Resident #3's recliner in his room. Observation throughout the survey showed Resident #3 spent most of his day sitting in his recliner. During an interview on 08/09/16 at 10:50 a.m., a therapy staff member (#14) stated, "That cushion (pressure relief) doesn't have a cover. It (the cloth/quilted incontinent protector on top of the cushion) takes away the pressure relief properties." During an interview on 08/09/16 at 11:00 a.m., an administrative nurse (#1) responded when informed the cloth/quilted incontinent protector was observed on top of Resident #3's pressure relieving cushion, stated, "no that's not how they (pressure relief cushions) are to be used." The facility failed to utilize the pressure relief cushion properly to aid in healing and prevent additional skin breakdown for Resident #3. The presence of another layer (cloth/quilted incontinent protector) on top of a pressure relieving cushion decreased the effectiveness of the cushion.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		9/23/16

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F 323	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, review of manufacturer guidelines, review of policies, and staff interviews, the facility failed to ensure adequate supervision of assistive devices for 2 of 4 sampled residents (Resident #6 & #7) who required extensive assistance with transfers. Failure to appropriately utilize a gait belt (Resident #6) and a mechanical stand lift (Resident #7) during transfers placed the residents at risk for sustaining a fall or injury. Findings include: Review of the mechanical lift manufacturer guideline titled "Patient Lifting Instruction and Sling" occurred on 08/10/16. This undated guideline, stated,"Lifting patient from a chair . . . raise the boom until just clear of the chair. Make any minor sling adjustments at this point and check the patient's safety and comfort. Once certain of the patient's safety and comfort, proceed in lifting the patient." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 10th edition, Pearson Education, Incorporated, New Jersey, (2016), page 1033, states,". . . A sit-to-stand power lift allows for client transfers from bed to chair. The client must be cognitive and provide some muscle tone in at least one leg and the trunk. . . ." - Review of Resident #7's medical record occurred on August 09-10, 2016. Diagnoses included cerebral palsy and osteoporosis. The	F 323	1) An assessment has been completed by Physical and Occupational therapy on resident # 7 to ensure we are using the correct transfer device. An assessment has been completed by physical therapy on resident # 6 to ensure we are using correct transfer technique. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) All CNA and Nursing staff have been educated on transfer technique with residents # 6 and # 7 at meetings held in August. Monthly education will be provided by PT at CNA meetings to discuss transfer techniques based on audit findings. 4) An audit will be completed by the PT department bi-weekly x 12 months on 5 random transfer to ensure residents are being transferred appropriately. The audit will be reviewed monthly at the Quality Assurance Meetings.	

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annual Minimum Data Set (MDS), dated 07/08/16, identified one sided impairment in range of motion of both the upper and lower extremity and two person extensive assistance with transfers.

The current care plan stated, ". . . Focus . . . has limited physical mobility r/t [related to] contracture & deformities of [left] leg & arm due to cerebral palsy & fx [fracture] [left] arm M/B [manifested by] inability to transfer independently . . . Interventions/Task . . . [left] ARM HAS NO FUNCION [sic], LEFT LEG AND KNEE HAVE LITTLE FUNCTION . . . [RIGHT] ARM DECREASED MOBILITY DUE TO hx [history] OF FX . . . Focus . . . has an ADL [activity of daily living] self-care performance deficit r/t [related to] musculoskeletal impairment & cerebral palsy . . . Interventions/Tasks . . TRANSFER: [name of resident] requires Mechanical Lift; sit-to-stand lift with 2 staff assistance for transfers. when transferring into [wheelchair] please tilt the chair forward, . . . assist her by placing her buttocks toward the back of chair where she is more comfortable . . ."

Review of the transfer lift assessment, dated 01/24/14, stated,". . . Staff must be instructed on correct use of sling . . ."

Observation on 08/09/16 at 5:09 p.m. showed two certified nurse assistants (CNAs) (#2 and #4) transferred Resident #7 from the wheelchair to the bathroom utilizing a mechanical stand lift. The CNA's (#2 and #4) raised Resident #7 to a standing position, the abdominal belt slid up to Resident #7's mouth. The resident's left hand hung by her side while she held onto the lift with

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her right hand. The CNAs (#2 and #4) failed to ensure the sling belt did not move during transfers and failed to ensure the resident was safe to transfer with limited function.

Observation on 08/10/16 at 9:36 a.m. showed two CNAs (#3 and #5) transferred Resident #7 from her wheelchair to the bathroom utilizing a mechanical stand lift. The CNA's (#3 and #5) failed to tighten the abdominal strap prior to starting the transfer. The resident's left hand hung by her side while she held onto the lift with her right hand. The abdominal strap loose and slid up touching mouth. Resident #7's left foot did not touch the foot rest while the right foot did. Buttock hung from sling. Placed on toilet.

During an interview on 08/10/16 at 10:10 a.m., an administrative nurse (#1), confirmed staff failed to properly or safely transfer Resident #7.

Review of the facility policy titled "Gait Mechanics" occurred on 08/10/16. This undated policy stated, ". . . Place belt [gait belt] around resident's waist . . . Make sure the belt is securely buckled so it does not slide. . . When holding the belt and [sic] underhand grasp should be used. . . ."

Review of the facility policy titled "Transfer Activities" occurred on 08/10/16. This undated policy stated, ". . . ASSESSMENT GUIDELINES May include, but are not limited to: Loss of range of motion . . . Ability to perform ADL's, contractures, . . . Ability to stand and bear weight, . . . loss of voluntary control of extremities, paresis or paralysis . . . gait belt . . . Hold the transfer belt from underneath . . . and lift client to

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a standing position . . . Support may be provided by use of a transfer belt. . . ."

- Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 05/19/16, identified Resident #6 required extensive assistance of two people with transfers. The current care plan failed to include interventions to address Resident #6's transfer needs.

Review of the physical therapy restorative progress notes stated the following:
* 04/07/16 at 4:23 p.m.: ". . . We will continue to monitor her for development of contractures or limitations in ADLS due to movement impairment. We will then try to address those issues at that time."
* 05/19/16 at 4:04 p.m.: ". . . She does have some limitation on UE [upper extremity] . . . She is needing mod-maxA [moderate-maximum assistance] of 1-2 people to transfer or use of lift. She does not amb [ambulate] at this time. . . . We will continue to monitor her mobility needs and ROM [range of motion]."

Observation on 08/07/16 at 5:08 p.m. showed two CNAs (#3 and #4) transferred Resident #6 from her bed to the wheelchair utilizing a gait belt. The CNAs sat Resident #6 up on the edge of the bed, applied a gait belt around the resident's waist, and utilized a pivot stand transfer with the gait belt to the wheelchair. During the transfer the gait belt slid up under the resident's bilateral axilla. The CNAs failed to ensure the gait belt was in the proper position during the transfer.

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F 323	Continued From page 40 Observation on 08/08/16 at 10:39 a.m. showed two CNAs (#18 and #19) transferred Resident #6 from her wheelchair to her bed utilizing a gait belt. During the transfer, the CNA (#18) held onto the gait belt with her left hand and placed her right hand on the residents buttock to push her up to a standing position. Observation on 08/08/16 at 11:44 a.m. showed two CNAs (#18 and #19) transferred Resident #6 from her bed to the wheelchair utilizing a gait belt. During the transfer, the CNA (#18) held onto the gait belt with her left hand and onto the resident's pants with her right hand as the resident pivoted into the wheelchair. Observation on 08/08/16 at 1:46 p.m. showed two CNAs (#18 and #19) transferred Resident #6 from the recliner to her wheelchair utilizing a gait belt. During the transfer, the CNA (#18) held onto the gait belt with her left hand and placed her right hand on the resident's buttock to push her up to a standing position. Observation on 08/08/16 at 5:17 p.m. showed two CNAs (#17 and #20) transferred Resident #6 from her bed to the wheelchair. During the transfer, the CNA (#17) held onto the gait belt with one hand and placed her other hand on the resident's buttock to push her up into a standing position. The CNA (#20) held onto the gait belt and grabbed the resident's pants with her other hand pulling her up into a standing position. During an interview on the morning of 08/10/16, an administrative nurse (#1) stated she expected staff to utilize the gait belt during transfers and not the resident's clothing.	F 323		

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F 323	Continued From page 41 The facility failed to appropriately utilize assistive devices during transfers which placed the residents at risk of falls/injury.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		9/23/16

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F 431	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to properly secure and label all medications on 2 of 2 days (August 08-09, 2016) during observation of medication pass. Failure to store and label all medications correctly may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Oral Medication Administration" occurred on 08/10/16. This undated policy stated, ". . . Compare the Medication label with the MAR [medication administration record] three (3) times to ensure accuracy. . . ." The facility lacked a policy on medication storage. - Review of Resident #1's current physician order showed the scheduled dose of subcutaneous NovoLog 10 units. Observation during medication pass on 08/08/16 at 10:54 a.m. showed a nurse (#9) prepared Resident #1's medications, including NovoLog insulin. The label affixed to the NovoLog vial identified 8 units to be administered before meals. The nurse (#9) prepared 10 units of NovoLog insulin, administered the insulin, and failed to recognize the label and the eMAR did not match. -Review of Resident #8's current physician order	F 431	1) The label for novolog insulin on Resident #1 and # 8 has been corrected. 2) All residents admitted to the skilled nursing facility have the potential to be affected by this deficient practice. 3) Current practice has been reviewed and will be revised to have a label placed on resident's medication when dosing changes are ordered. A new label will be ordered from pharmacy and placed by pharmacist within 24 hours. All nursing staff have been educated on this change in practice. 4) An audit will be completed by DON bi-weekly x 12 months on 5 random medication changes to ensure that warning label is placed appropriately and new label is ordered. The audit will be reviewed monthly at the Quality Assurance Meetings.	

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F 431	Continued From page 43 showed the scheduled dose of subcutaneous NovoLog 10 units. Observation during medication pass on 08/08/10 at 11:05 a.m. showed a nurse (#9) prepared Resident #8's medications, including NovoLog insulin. The label affixed to the NovoLog vial identified 8 units to be administered before meals. The nurse (#9) prepared 10 units of NovoLog insulin, administered the insulin, and failed to recognize the label and the eMAR did not match. The facility failed to obtain new labels with the correct physician's order for the insulin medication. During an interview on the afternoon of 08/09/16, an administrative nurse confirmed the medication labels should match the physician orders. Observation during medication pass on 08/09/16 from 7:45-8:00 a.m. showed medications placed on top of an unattended medication cart in the dining room. The medications included one bottle of liquid Potassium Chloride, one bottle of daily vitamins, one bottle of ibuprofen (pain reliever), two bottles of aspirin, one bottle of stool softener, one bottle of acetaminophen (pain reliever), and one bottle of Gavilax (laxative). During an interview on morning of 08/09/16, an administrative nurse (#1) confirmed all medications should be stored and locked in the medication carts when unattended.	F 431		